REDUCING INAPPROPRIATE USE OF MEDICAID EMERGENCY TRANSPORTATION SERVICES

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2/4/2011

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Introduction

If you cannot pay for medical care, you may be eligible for coverage through Medicaid. The United States currently has the largest program designed to cover medical and health-related services for people with low or limited income.[1] Medicaid is funded from both federal and state governments. Even though the federal government funds part of Medicaid, the program is managed by each state. With limited exception, Medicaid covers most transportation costs to all of its eligible members.

The Medicaid program, as established by Title XIX of the Social Security Act, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities. Title XIX of the Social Security Act and accompanying regulations require that each state, through their Medicaid program, cover medical care and services and fulfill administrative requirements necessary to operate the Medicaid program efficiently.[2]

Although the state has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan. The mission of the SCDHHS is to manage the Medicaid program to provide the best healthcare value for South Carolinians.

[1]Kaplan, Kimberly. Does Medicaid Cover Transportation. eHow. http://www.ehow.com/print/about_5335992_medicaid-cover-transprtation.html

[2]Medicaid Ambulance Services Provider Manual, http://www.scdhhs.gov/internet/pdf/manuals/Ambulance/SECTION%202.pdf

State Medicaid agencies are mandated by the Centers for Medicare and Medicaid Services (CMS) to ensure necessary transportation for recipients to and from medical providers and describe methods that the agency will use to meet this requirement. While transportation may not always be a medical service, it ensures that individuals can get to and from needed care and thus is necessary for the effective administration of Medicaid-funded health care services. The transportation benefit includes transportation expenses and related travel expenses deemed necessary by the State Medicaid agency to secure medical examinations and treatment for a member. The State of South Carolina administers both emergency and non-emergency transportation services. For the last three consecutive state fiscal years, the total expenditures for emergency transportation services have been in excess of $50 million.

Needs Statement

Transportation is a common target for Medicaid fraud. Transportation providers do not need a medical license or higher education, so it is an easy area for criminals to infiltrate. A simple check of administrative claims may turn up thousands of dollars of transportation services that were provided to members who did not receive a medical service on the day of transport.

The Department of Health and Environmental Control (DHEC) Code of Regulation 61-7, South Carolina Code of Laws of 1976, Statutory Authority Section 44-61-150, sets forth the current minimum standards for ambulance operations in South Carolina. South Carolina Medicaid will only reimburse ambulance providers who are in compliance with all current DHEC

regulations, including revisions, for the services rendered. Out-of-state providers must be licensed and certified by their respective states.[3]

Emergency ambulance transportation is considered medically necessary if: the member is transported in an emergency situation (i.e., result of an accident, injury, or acute illness) and the Department of Health and Environmental Control (DHEC) Ambulance Run Report justifies the condition and/or treatment of the level of service billed. Each time an ambulance service responds to a call, South Carolina law requires that a DHEC approved Ambulance Run Report be completed to document the trip. The Ambulance Run Report is a medical document that can be used to record a patient's treatment and must be maintained in the beneficiary's record for all ambulance transports.

In June 2003 Hattie and Barry Bull, owners of "H and B Transportation", pled guilty to overcharging Delaware's medical assistance program and overstating mileage on patient trips. They were ordered to pay $100,000 in restitution and $12,930 in fees to the Attorney General. The Bulls were sentenced to a five year prison term which was suspended for probation.[4]

Hypothesis

Medicaid covers emergency transportation services which may not meet the medical necessity criteria. Medicaid can reduce the cost for emergency ambulance transportation services through a comprehensive approach to reimbursement for these services. The desired outcome is to reduce the number of ambulance claims being paid which do not meet the

[3]Medicaid Ambulance Services Provider Manual, http://www.scdhhs.gov/internet/pdf/manuals/Ambulance/SECTION%202.pdf

[4]Mathias, Robin. Medicaid Transportation Fraud. July 22, 2003. Mathias Consulting. www.mathiasconsulting.com/node/94.

emergency medical necessity criteria.

With the implementation of the Non-emergency Transportation Brokerage system in May 2007, the transportation costs overall have decreased. Prior to the brokerage system all transportation services were monitored in the local Department of Social Services offices. About five years before the brokerage system was implemented, administration of the transportation services was delegated to the Department of Health and Human Services. Staff from the state DSS office was transferred to the Department of Health and Human Services.

The brokerage system includes all routine, non-emergency transportation services. All medically necessary non-emergency ambulance services are still monitored through DHHS. Since more focus has been on improving the brokerage system, there has been very little analysis of the emergency transportation services. For many providers, they may think "out of sight, out of mind" which concerns me not only as a taxpayer but a manager.

Data Collection

For this project, I chose to collect data from two sources: Medicaid paid claims data and provider medical records. I reviewed Medicaid claims data for the past three state fiscal years (2007-2009). I randomly selected medical records from select providers and reviewed the documentation for emergency ambulance transports. Documentation included the CMS-1500 Claim Form, DHEC Ambulance Run Report, and any additional information (i.e., medical records) related to the ambulance transport.

Medicaid currently reimburses providers through the Medicaid Management Information System (MMIS). Providers submit claims using the CMS-1500 Claim Form. The

claims are keyed and processed through a third-party vendor. If the claim is clean or error-free, the provider will receive payment through Electronic Fund Transfer and a Remittance Advice is posted electronically on the Web Tool electronic claim processing system.

Medicaid claims data was extracted through the MedStat Advantage Suite system. Advantage Suite, Thomson's flagship product, is designed to meet the analytic and reporting needs of a wise range of users from executive decision makers looking for quick answers to power users responsible for in-depth research and analysis. One of its integrated components is Decision Analyst, a powerful report writer and query tool. It gives users access to the full database including Thomson's healthcare measures catalog, and provides sophisticated analytic functions that allow users to subset the data, drill to detailed records, and create study groups for special analyses.

The Medical Conditions List contains the general International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 CM) that fit the transport conditions. Ambulance providers and suppliers use the Medical Conditions List to communicate the patient's condition, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of a claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be readily available and are subject to medical review.

Data Analysis

Once the data collection was completed, I was able to review the data for any trends or patterns. The data included forty-five (45) records from three (3) ambulance providers for services billed and reimbursed by Medicaid for the past three state fiscal years (2007-2009). The providers were chosen because they had the highest reimbursement for this time period. In reviewing the data, it appears that the provider claims are valid and the transportation services were provided to a Medicaid member. There were some discrepancies as to whether the service met the medical necessity criteria as established by Medicaid. All of the services were actually emergency or 911 calls. However, the member may not have required "lights and siren" to be transported to the medical facility.

Ambulance companies do not currently have a protocol in place to change the status of the call once they arrive at the scene. For example, if a call comes in as emergency or 911, the ambulance crew will not contact the broker if it determined on arrival that the trip is non-emergent. The ambulance crew will run the call and bill it as an emergency call, presumably because the rate for emergency ambulance calls are higher than the broker payment for non-emergency calls.

In viewing the paid claims data for the emergency ambulance service, the provider may bill using a valid ICD-9 and emergency procedure code. The ICD-9 code used by the provider is determined by the dispatch description when the call is placed. The provider files also document that the member was transported emergent as indicated on the DHEC Run Report; however, the narrative summary on the Run Report does not support that the transport was truly emergent (See Appendix A and B).

Implementation Plan

For non-emergency, medically necessary transportation services, the current process is a claim is submitted to a third party vendor by an enrolled ambulance provider. The claim must be submitted with documentation (i.e., DHEC Run Report and the DHHS Form 216). The claim processor will key the claim into the system. The claim then suspends to the program area for manual review.

When the program manager receives the suspended claim, the documentation is attached. The program manager has to review the claim form and documentation to determine if the transport was medically necessary. If the claim was medically necessary, the program manager will force the claim by circling the edit code and return it to the third party vendor for processing. If the claim does not meet medical necessity criteria, the claim is rejected by placing an "R" on the claim form and returning it to the third party vendor for processing. The ambulance provider may resubmit the claim with the proper documentation for payment.

Currently, when an emergency ambulance claim is submitted to the third party vendor for payment, as long as the claim is error-free, it will process through the claims processing system. There is no gate keeping in place for emergency ambulance claims. Due to the high volume of emergency ambulance claims processed through the claims payment system, it would be difficult, and may require additional staff, to implement a system such as the non-emergency medically necessary ambulance claims.

For a project that could potentially save DHHS about ten percent (See Appendix C) over the course of two years and contain the cost, the implementation process may be simple. I will make contact with the Office of Medicaid Research, an area within DHHS responsible for reporting, to have a monthly report built. The report file will contain the provider's name, provider number, total expenditures to date, and expenditures for the previous fiscal year. This report would then be ranked by total expenditures to date. The program manager would then conduct an unannounced visit to the three ambulance provider with the highest expenditures. We will develop a checklist of items for the

therefore, more willing to bill appropriately. For example, even if a call is 911 when an ambulance arrives on the scene and determines the member does not need lights and sirens, the ambulance company will have to have their dispatcher contact the Medicaid transportation broker to change the trip type.

Evaluation Method

The best plan to evaluate the cost savings for implementing this project is to monitor the emergency transportation services expenditures. I would have the Medicaid Office of Research to develop an expenditure monitoring dashboard for emergency transportation services. The report will be set for a program manager with MedStat access to run the report monthly. Cost savings will be reported monthly to management.

Summary and Recommendations

Based on the findings from this project, I will recommend that other program areas within the agency review their services and implement projects to reduce or contain cost as the Medicaid role continues to increase.

APPENDIX A

1500

0 1103804110085Q 11035 p 001

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD 02 08 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

STATE SC

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY

STATE SC

ZIP CODE

TELEPHONE (Include Area Code)

ZIP CODE

TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

SECOND FOLD

FIRST FOLD

WHCP-10-SHV / WHCP-10-SHV-08

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. L78609

2. L78603

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 0 00

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 20 10	03 20 10	41		A0427	HH	1	400 00	1		ID NPI	
2 03 20 10	03 20 10	41		A0425	HH	1	88 00	8		ID NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 488 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 488 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGN

32. SERVICE FACILITY LOCATION INFORMATION

FROM: LEXINGTON MEDICAL CENTER - 29169-

TO: PALMETTO HEALTH RICHLAND - 29202-

a.

b.

33. BILLING PROVIDER INFO & PH. # (803)

a.

b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

AMS AMBULANCE

AMS Patient Transfer Form

Trip Number 116 31960

BLS NON-EMERGENT ☐ BLS EMERGENT ☐ ALS I EMERGENT ☐ ALS II EMERGENT ☐

Patient Name _____ Phone (803) _____ SSN _____ DOB 2/8/10 Age 1 month

Address _____ 29034

Beginning Mileage 96737 Ending Mileage 96745 Pick Up LANCER TRAUMA Destination RICHLAND PEDS ICU 7621

Unit # 116 11 Driver: L. SHERWOOD Primary Attendant: W HARTZOG

Times & Codes: To Scene: 1 ✓ or 3 ___ DISP 0245 ENR 0247 ON SCN 0311 LVS 0325 DEST 0336 AVAIL 0351 To Dest: 1 ✓ or 3 ___

Reason for Ambulance Transport

CVA	☐	Spinal	☐	Diabetic	☐	Sprain/FX	☐	Oxygen	☐
Cardiac	☐	AMS	☐	Behavioral	☐	Fall	☐		
Respiratory	☐	GI/GU	☐	Abrasion/LAC	☐	Dialysis Patient	☐		

Other ☐ _____

History None

Medications None

Allergies NKDA

Vital Signs / Interventions

Blood Pressure	84/40	Time	0325					
Pulse	140	Time						
Respirations	32 100%	Time						

Color _____ Condition _____ LOC _____ Pupils _____

GCS/RTS ___/___ EKG _____ BGL _____/_____

Epi _____ ASA _____ Lasix _____ Morphine _____ Atropine _____

Nitro _____ D50 _____ Valium _____ Vaso _____ Amiod _____ Albuterol _____

Other _____

Observations/ treatment/CC/HPI CC "

Acknowledgements & Authorization for HIPAA

I authorize benefits payable under the Health Insurance Portability and Accountability Act to AMS and release of information to facilitate payment. I also acknowledge that I have been provided with a copy of the AMS, Inc. Notice of Privacy Practices.

Patient ☐ Representative ☒ Other ☐ Patient unable to sign due to: Dementia ☐ Other ☐

3-20-2010 _____ 3/20/10

Signed By Date Witness By Date

Recent 7-19

488.02

_____ 3/20/10

Receiving Nurse or Physician Date

Untitled

cc- Respiratory Distress HPI-pt had an apneic spell after choking due to coughing and vomiting, cousin performed CPR and pt came back conscious, when EMS arrived @ residence pt was apneic however had a pulse, pt had one other episode of apnea en route to ER, LMCER requests for pt to be transferred to Richland Peds ICU for further evaluation for further risks of apnea resulting in death PMH- None Meds- None All-NKDA PE-AOS to find 1 month old 8/F pt being held by mother, conscious and alert to normal mental status per mother, patent airway, breathing normal 32 and unlabored, BBS C/E, skin w/d color normal, SPO2 on RA 100%, PEARL, PMSX4, pt in no obvious distress, pt resting comfortably in mothers arms Rx- pt mother seated on FW w/ pt on lap, mother and pt secured, v/s obtained prior to departing ER, FW to unit, v/s monitored en route, no changes noted, upon arrival @ Richland pt was taken to the Pediatric ICU unit and placed in bed, verbal report to RN, pt care and paperwork transferred to staff

Lexington Medical Center Triage

Category: 2 Unstable

ID: H00044588788

Arrival Date/Time	Registration	Waiting Room Time	Exam Start Time
3/20/2010 0:23	0:23		0:23

Patient Name:

Medical Record Number:

Acct Num/Number:

DOB:

Age: 1 Months

Gender: Female

Arrival Status: Not on Staff

Private Vehicle: delaney

Transported by: Ambulance

Mode: Stretcher

Police Dept: Custody / Notification / Beat #

Police: Ambulance (Count

Chief Complaint: apnea

Onset Time/Location:

Associated Symptoms/Additional Info:
apneic spell after choking tonight cousin perform compressions and ventilations, when ems arrived pt having apneic spell but had pulse. ; vaginal delivery currently on good start soy; seen at md on Wednesday dx with uri no meds given at that time

Past Medical History: Additional:

- ✔ No Significant PMHx
- Asthma, COPD, CAD, Cancer, CHF, CVA
- DM, HTN, Psych, Renal, Seizures

Medications:

- ✔ No Meds
- Unknown

Allergies:
No Known Drug Allergies

Immunization Status: Not UTD
TB Hx, PPD Pos or Infectious Exposures? No
*If yes to TB or Infectious question take precautions

Mental Status/Psychological Level:

Lung Sounds:

	R	L
Clear		
Diminished		
Wheezes		
Rales		
Rhonchi		
Retractions		

Eyes:

	R	L
Equal	✔	✔
Reactive	✔	✔
Fixed		
Constricted		
Dilated		
Cataract		

Glasgow Coma Scale:

Eye	Spontaneous
Verbal	Oriented
Motor	Obeys
Total	15

OB/GYN:

G	P	Ab	Miscarriages
0	0	0	0

Skin:

Color	Normal
Temp	Normal
Moist.	Normal

Extremities:
Pulses: All Pulses Intact
ROM: Full ROM

Vitals:

Temp
- Oral:
- Rectal: 99.5
- Tympanic:

Pulse
- Right:
- Left: 155

Respirations: 32

Blood Pressure
- Right:
- Left: 108/69

Pulse Ox: 100%

Weight (Kg): 4 Kg

Height / Head Circumference:

Pain Scale: No Pain

Nutrition:

Fall Risk Assessment:
No Fall Risks Identified

Domestic Violence Assessment:
Are you being hurt by someone you live with or who takes care of you?
Yes/No: No
* Mandatory completion of Domestic Violence Referral.

Activities of Daily Living:

Daily Living	Dependent
Living Conditions	Family
Going Home with	Mother

Learning Preferences:

Primary Language	English
Assessed Disability	No Disability
Communication Barrier	
Language Translator	
Motivation Level	Med
Knowledge Level	Med
Comprehension Ability	Med

Triage:
2 -tr
Time: 0:23
Triage Nurse:
Triage II: SPG
Triage III: SPG

LWBS | LW Completed Tx/ Eloped | AMA | AMA Refused | ✔ Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

Patient Name | Medical Record No.

Account Number | Date 3/20/2010

ID

Lexington Medical Center

Emergency Department Record

History of Present Illness

ER

1 Month Old Female Patient Presents with apnea. The Onset is choking (S/P). Symptoms improve with none. Additional Symptoms or Pertinent History also involve 5.5 wk old 37wk svd without complication, saw pcp ([redacted]) 3/17 and dx with URI. No meds given.. Furthermore, the Patient/Family Denies fever, dec appetite, dec uop, recent abx, diarrhea. Patient states exacerbating Factors that occur are none. Symptoms were congestion, cough and runny nose. Tonite was sleeping, then had coughing/gagging and vomited. Mom suctioned nose and mouth then baby stopped breathing, became limp, and face turned blue. Cousin started cpr. Was still nonresponsive when ems arrived. Second apneic episode en route that resolved with stimulation. This is mom's second child (first is 6yr old). Vomits on occasion. Hx from mom. Add hx from ems. Had 2 abnormal tests for markers of Cystic Fibrosis, sweat test inconclusive b/c not enough sweat obtained during exam..

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU Neg | Neuro | ENT Pos | Resp Pos | Musculoskeletal Neg | Hematologic/Lymphatic

Skin Neg | Psych | Heart Neg | GI Pos | Endocrine Neg | Allergic/Immunologic

All other ROS negative | Constitutional Sxs Neg | Eyes Neg

✔ Vital Signs/Triage/Nursing Notes Reviewed and Agree | Hx unobtainable due to Tx urgency or poor historian(s) | ✔ Additional Information from Police, Ambulance, Nursing Home or Relatives | ✔ Old Medical Records

Past Medical History ✔ No Relevant PMHx | Asthma | COPD | CAD | Cancer | CHF | CVA

Other PMHx | Diabetes | HTN | Psychiatric | Renal | Seizures

Social History No Relevant SoHx | ETOH | Drugs | Smoking | Additional Sx: lacks first vaccines (did receive Hep B after birth). Bottle fed.

Family History ✔ No Relevant FmHx | No Significant FMHx

Physical Exam

Exam Time: 0:32

ER

General Appearance	awake, being held by mom, sucking on pacifyer
HEENT	nc/at, perrl, fontanelle flat, mmm
Chest	RRR s MRG Lungs CTA s retractions Chest wall unremarkable
Abdomen	Abd wall s hernias/abn findings NL BS SoR, NT s HSM/mass
GU	Normal for age
Extremities	Throughout all extremities Appearance normal CR < 2 sec Full AROM Nontender
Neuro	
Skin	neonatal acne face/back
Back	NT, No deformities/tenderness, NL ROM for age
Neck	Supple
Lymphatics	No obvious lymphadenopathy

Repeat or Additional Clinical Notes

MD	Notes	Time	
ER	.Renwick MD-Primary ED Provider. Any lab test results, plain radiographs, ABG's, EKG's, and Pulse Oximetry were independently visualized and interpreted by this provider.	3/20/2010	0:41
ER	cxr 3/17 with viral pneumonitis	3/20/2010	1:35

Patient Name

Medical Record No. [redacted]

Account Number

Date 3/20/2010

Diagnostics

Specimen Collected / ECG Red Ordered

MD Initials	Date/Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
SPG	3/20/2010 0:27	Pulse Ox	Normal	ER	SPG	0:27
ER	3/20/2010 0:32	RSV	RSV-NEG	ER	SPG	0:41
ER	3/20/2010 0:32	Chest X-ray PA/lateral	viral pneumonitis	ER	SPG	0:48
ER	3/20/2010 0:32	Urine Cx	Pending	ER	SPG	1:05
ER	3/20/2010 0:32	Urinalysis	U LE-NEG,U Nit-NEG,U Prot-SMALL,U Ket-NEG,U Bil-NEG,U WBC-0,U RBC-0,U Blood-NEG,U Glucose-NEG,U Urobili-NORMAL,U Type-CATHETERIZED URINE,U SpGr-1.015,U pH-8.0,U Color-YELLOW,U SqEpi-<1	ER	SPG	1:05
ER	3/20/2010 0:32	CBC	WBC-8.9,HGB-10.7,HCT-30.7,Platelets-748,Neutro-19,Bands-1,Lympho-61,Eos-6,Mono-11,RBC-3.24,MCHC-34.8,MCV-94.8,RDW-17.0,AbsBand-0.09	ER	SPG	1:05
ER	3/20/2010 0:32	BMP/Chem-7	NA-135,K-5.0,CL-109,CO2-19,BUN-5,CREA-0.32,GLU-84,CA-9.9,AGAP-8	ER	SPG	1:05
ER	3/20/2010 0:32	Blood Cx	Pending	ER	SPG	1:05
ER	3/20/2010 0:33	Influenza Nasal Swab	RFLUA-SEE COMMENTS,RFLUB-SEE COMMENTS	ER	SPG	1:05
ER	3/20/2010 0:33	Continuous Pulse Ox	100% ra	ER	SPG	0:48

MD Procedures

Procedure Description	Comments
Time 2:20 MD SPG Pulse Ox	
Time 3:20 MD ER Continuous Pulse Ox	94762-26 CPT

Recommended LOS/CPT/ICD-9 Codes

Physician's LOS = 5 99285-26

Nurse's LOS = 5 612 APC

Diagnoses

apnea	786.03 ICD-9
acute life threatening event	
apnea	786.03 ICD-9
viral pneumonitis	

Notifications

MD Notified	Time Notified	MD Init
[redacted], peds resident Palm Richland Discussed Relevant Hx, Exam, Diagnostic Evaluation & Disposition-Agrees c Plan.	2:20	ER

	MD	MD Time		RN	RN Date/ Time	Admit to
Disposition	ER	1:36	Transfer Palmetto Richland	SPG	3/20/2010	3:17
Condition	ER	2:19	Guarded	SPG	3:17	

Physician (Print)

Other Physicians

Patient Name

Medical Record No.

Account Number

Date 3/20/2010

Physician Signature

(ER)

Primary RN (Print)

Other Nurses or ED Staff

This chart has been electronically signed via the EmpowER software.

Patient Name
Account Number

Medical Record No.

Date 3/20/2010

Lexington Medical Center

Emergency Department Nursing Notes and Vital Signs

TimeEntered: 3/20/2010 2:00 Vitals Taken By: SPG

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O	Right		R	32	100%	No Pain
T	Left	140	L xx/xx			
R						

TimeEntered: 3/20/2010 3:16 Vitals Taken By: SPG

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O	Right		R	32	100%	No Pain
T	Left	140	L 86/40			
R 97.7						

Nursing Notes

Time Note Entered		RN Initial	Note
3/20/2010	0:23	SPG	Pt crying upon arrival to er, skin warm dry resp nonlabored, hr st regular, abd soft slightly distended, moves all extremities, fontanel soft and flat
3/20/2010	1:17	SPG	Int x 1 attempt unsuccessful blood drawn sent to lab , urine collected I & O cath obtained clear yellow urine out pt easily consoled per mom and staff
3/20/2010	3:17	SPG	Arms present to transport pt tolerated 3ounces formula no choking or apnea episodes while here

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved
Tissue Perfusion, Altered	Demonstrates Decrease S & S	Yes

Primary RN (Print)

APPENDIX B

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 01/31/10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 781 0

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 31 10 | 01 31 10	41	9	A0427	NH	1	375 00	1		NPI	
2	01 31 10 | 01 31 10	41	9	A0425	NH	1	687 06	82		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE $ 1062 06

29. AMOUNT PAID $

30. BALANCE DUE $ 1062 06

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Patient Care Record

Name: [redacted] Incident #: 24220 Date: 01/31/2010 Patient 1 of 1

Patient Information

[redacted]

Clinical Impression

	Other
	TREMORS
	1 Units: Days
	Units:
	Other -
	-
	Medical

Medication Allergies History

Medication	Other - PT TAKES MULTI MEDS. LIST BROUGHT TO ER WITH PT.
Allergies	NKDA -
History	Behavioral/Psychiatric Disorder - ; Coronary Artery Disease - ; Diabetes - ; Gastrointestinal problems - ; Hypertension - ; Other - BLIND L EYE. ANEMIA. SEPSIS RESOLVED. VERTIGO.; Renal Failure - ; Stroke/CVA -

Vital Signs

14:17	A	L	Lay	120/70 M	68 R	18 R	97			90				8	
14:32	A	L	Lay	121/68 A	68 R	20 R	100							8	
14:52	A	R	Lay	120/67 A	68 R	20 R	100							8	
15:12	A	R	Lay	122/64 A	68 R	20 R	100							8	
15:25	A	R	Lay	131/65 A	72 R	20 R	100							8	

ECG

14:17	
14:32	Sinus Rhythm
14:52	Sinus Rhythm
15:12	Sinus Rhythm
15:25	Sinus Rhythm

Flow Chart

14:30	ALS Assessment	Comments CARDIAC MONITOR. SINUS RHYTHM; SEXTON, BRIAN

Initial Assessment

Mental Status	⊕Other ⊖Combative, Confused, Hallucinations, Unresponsive	PT SPEAKS VERY LITTLE DUE TO S/P CVA; HOWEVER, DOES FOLLOW MOST COMMANDS. EYES ARE SPONTANEOUS.
Skin	No Abnormalities	
HEENT	Head/Face: ⊕Facial Droop Eyes: ⊕Left: Blind Neck: No Abnormalities	
Chest	Chest: No Abnormalities Heart Sounds: Not Assessed	
Abdomen	General: No Abnormalities Left Upper: No Abnormalities Right Upper: No Abnormalities Left Lower: Not Assessed Right Lower: No Abnormalities	
Back	Cervical: Not Assessed Thoracic: Not Assessed Lumbar/Sacral: Not Assessed	
Pelvis/GU/GI	Not Assessed	
Extremities	Left Arm: ⊕Weakness Right Arm: No Abnormalities Left Leg: ⊕Weakness Right Leg: No Abnormalities Pulse	
Neurological	⊕Facial Droop, Slurred Speech, Tremors, Weakness Left-Sided ⊖Abnormal Gait, Other, Seizures, Weakness Right-Sided	NORMAL FOR PT DUE TO S/P CVA.

Patient Care Record

Name: | Incident #: 24220 | Date: 01/31/2010 | Patient 1 of 1

Ongoing Assessment

Mental Status	⊕Other		PT EYES ARE SPONTANEOUS. PT FOLLOWS MOST COMMANDS. PT SPEAKS VERY LITTLE DUE TO S/P CVA.
Skin	No Abnormalities		
HEENT	Head/Face	⊕Facial Droop	
	Eyes	⊕Left: Blind	
	Neck	No Abnormalities	
Chest	Chest	No Abnormalities	
	Heart Sounds	Not Assessed	
Abdomen	General	No Abnormalities	
	Left Upper	No Abnormalities	
	Right Upper	No Abnormalities	
	Left Lower	No Abnormalities	
	Right Lower	No Abnormalities	
Back	Cervical	Not Assessed	
	Thoracic	Not Assessed	
	Lumbar/Sacral	Not Assessed	
Pelvis/GU/GI	Not Assessed		
Extremities	Left Arm	⊕Weakness	
	Right Arm	No Abnormalities	
	Left Leg	⊕Weakness	
	Right Leg	No Abnormalities	
	Pulse		
Neurological	⊕Facial Droop, Slurred Speech, Tremors, Weakness Left-Sided		NORMAL FOR PT DUE TO STATUS POST STROKE.

Narrative

C/C-TREMORS HX-PT DOES HAVE A PMH OF TREMORS; HOWEVER,; THE TREMORS ARE GETTING WORSE. ALSO, PT HAS NOT BEEN EATING OR DRINKING ANY FOR SEVERAL DAYS. PMH- S/P CVA WITH L SIDED WEAKNESS, RENAL INSUFFIENCY, CAD, HTN, BLIND L EYE, VERTIGO, DEPRESSION, ANEMIA. A- PT FOUND SEMI- FOWLER'S ON NURSING HOME BED, AWAKE. PT DOES FOLLOW MOST COMMANDS. LUNG SOUNDS CLEAR/ EQUAL. SKIN W/D. L SIDED WEAKNESS DUE TO S/P CVA. PT HAS CHRONIC TWITCHING OF EXTREMITIES. POSSIBLE WORSE TODAY. BGL -90 MG/DL. SINUS RHYTHM ON MONITOR. RX- EVALUATED/ MONITORED PT. TRANSPORTED- PT TO ER AS DIRECTED BY NURSE. PT MOVED/ TRANSPORTED ON STRETCHER IN SEMI- FOWLER'S POSITION. NO NOTABLE CHANGES ENROUTE. PT WAS MOVED BY DRAW SHEET TO ER STRETCHER. HEAD UP. SIDE RAILS UP. NURSE RECEIVED PT.

Specialty Patient - Advanced Airway

abc				

Specialty Patient - SAD

			Transported No Lights/Siren		14:06:14
			Physician		14:06:54
					14:07:41
			Physician		
			Hospital ER		14:08:33
			2720 Sunset Blvd.		
					14:28:31
	911 Response (Emergency)		West Columbia		15:26:11
	Lights/Sirens		SC		
	C Shift		29169		16:24:26
			Unchanged		

Crew Members

		Lead	EMT-Paramedic
		Driver	EMT-Basic

Patient Care Record

Name: [redacted] **Incident #:** 24220 **Date:** 01/31/2010 **Patient 1 of 1**

Insurance Details

[redacted]	Self
[redacted]	

[redacted]	
[redacted]	Immediate
[redacted]	

Delays

[redacted]

Additional Agencies

[redacted]	235138
[redacted]	235179
[redacted]	41
[redacted]	235137
[redacted]	235203
[redacted]	66

Next of Kin

[redacted]

Transfer Details

[redacted]	
[redacted]	
[redacted]	
[redacted]	ALS, Level 1
[redacted]	
[redacted]	Physician Order
[redacted]	
[redacted]	Stretcher-S/P CVA WITH L SIDED WEAKNESS.

Billing Authorization

[redacted]	English

Section I - Authorization for Billing

Signature

[redacted]	Agree	Disagree	PT Unable to Sign
	Agree	Disagree	PT Unable to Sign

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

- [redacted] Patient's Legal Guardian
- [redacted] Patient's Medical Power of Attorney
- [redacted] Relative or other person who receives benefits on behalf of the patient
- [redacted] Relative or other person who arranges treatment or handles the patient's affairs
- [redacted] Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for services rendered.

Signature

APPENDIX C

Medicaid Ambulance Tranportation Expenditures

FY 2007	FY 2008	FY 2009
$ 58,207,559.44	$ 15,005,268.26	$ 13,342,422.09

Source: Medicaid Transparency Report